MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12586 12568

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY Kent MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b 35 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 505 High St.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
d. STREET ADDRESS 505 High St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lillian Middle Lloyd Last Allen
4. DATE OF DEATH Month Dec. Day 9, Year 19 56

5. SEX Female
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 80 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John H. Allen
14. MOTHER'S MAIDEN NAME Sallie (Sarah) Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT J. Thos. Powell Address Hotel 2400 Washington, D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid and subdural hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: don't know
DUE TO (b) ~~Tha~~ & focal petechial cortical hemorrhage — recent
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Head injury probably sustained in a fall

9040

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive CVD with coronary sclerosis & old infarct
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. don't know
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home
20f. (City or town) Chestertown (County) Kent (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Robt Warr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 12/11/56
EXAMINER'S NAME (Type) Robert W. Farr

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec. 14 1956
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery
22d. LOCATION (City, town, or county) (State) Baltimore City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.
24a. REC'D BY REGISTRAR Dec. 13-56
24b. REGISTRAR'S SIGNATURE Clara L. Barnes

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12597

12569

CERTIFICATE OF DEATH

Reg. Dist. No. 2 02

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: KENT

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 1 YEAR
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN, 1

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: KENT & QUEEN ANNE'S
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DELIA Middle L. Last BARNES
4. DATE OF DEATH: Month DEC Day 26 Year 1956

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APR 2, 1877
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: SAMUEL LEE
14. MOTHER'S MAIDEN NAME: SCHUSTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NO
17. INFORMANT: HOSP. CHART. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS.
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): POST-OPERATIVE: RESECTION OF DUODENAL TUMOR
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-15, 1956, to 12-26, 1956, that I last saw the deceased alive on 12-26, 1956, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. T. Keefe M.D. ADDRESS (Street, city or town, state): CHESTERTOWN Md DATE SIGNED: 12-26-56

PHYSICIAN'S NAME (Type): A. T. KEEFE JR M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Dec. 28, 1956
22c. NAME OF CEMETERY OR CREMATORY: Chester Cem.
22d. LOCATION (City, town, or county) (State): Chestertown, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: Dec. 27-56
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12570

12596 CERTIFICATE OF DEATH

Reg. Dist. No. 2102

1. PLACE OF DEATH
a. COUNTY: KENT — Chestertown — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: RURAL
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD.
b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL CHESTERTOWN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: CLYDEA Middle: Last: BERTON

4. DATE OF DEATH: Month: DEC Day: 17 Year: 1956

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 11 1881

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS Coleman

14. MOTHER'S MAIDEN NAME: Louisa Wells

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Thelma L. Price — Address: Fairlee Chestertown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO

434.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Congestive Heart Failure — months

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260 X Diabetes Mellitus - Cystitis - 1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 12, 19 56, to Dec, 19 56, that I last saw the deceased alive on Dec. 12, 19 56, and that death occurred at 5 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas J. Solon, M.D. — ADDRESS (Street, city or town, state): Chestertown, Maryland — DATE SIGNED: 12/18/56

PHYSICIAN'S NAME (Type): THOMAS J. SOLON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Dec. 20 — 22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel — 22d. LOCATION (City, town, or county): Pork Hall (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Kane — ADDRESS: Church Hill Md. — 24a. REC'D BY REGISTRAR DATE: Dec. 22-56 — 24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

Item 18 Film 216 2-13-57 ems

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12538

12571

Reg. Dist. No. 307

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Annes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena
d. STREET ADDRESS: X
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LOUIS Middle — Last BROOKS

4. DATE OF DEATH: Month DECEMBER Day 26 Year 1956

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 2, 1902

9. AGE (In years last birthday): 54 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Labor

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Brooks

14. MOTHER'S MAIDEN NAME: Eleanor Benson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-16-9259

17. INFORMANT: Robert Brooks — Address: Galena Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Drowning~~ Intoxication — Possible ingestion bad whiskey — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b): Contusions & abrasions buttocks + back — (?) 5 days

DUE TO (c): Miniature hemorrhage - cerebellum — (?) 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

1. Lower nephron nephrosis and
2. Myocarditis with softening of muscle

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert W. Farr M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12/26/56

EXAMINER'S NAME (Type): ROBERT W. FARR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec 30 1956

22c. NAME OF CEMETERY OR CREMATORY: Worthy Hemp Cem.

22d. LOCATION (City, town, or county) (State): Galena Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Pellom — ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: JAN 3 1957

24b. REGISTRAR'S SIGNATURE: Clarence Parsons

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12572

12589 **CERTIFICATE OF DEATH**

Reg. Dist. No. 20-2

1. PLACE OF DEATH
a. COUNTY Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown Res

c. LENGTH OF STAY IN 1b 9 hours

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Millington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne General

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle DELA Last BURRIS

4. DATE OF DEATH Month December Day 10 Year 1956

5. SEX Femal

6. COLOR OR RACE Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Oct 24, 1924

9. AGE (In years last birthday) 32 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Gilbert Johnson

14. MOTHER'S MAIDEN NAME Alberta Hackett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 215-20-1881

17. INFORMANT Address Deceased - from hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized convulsive seizure (Eclampsia) — INTERVAL BETWEEN ONSET AND DEATH the same

DUE TO (b) Arterial hypertension — Don't know

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

642.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pregnancy - full term - (Autopartum death)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/13, 1956, to 12-10, 1956, that I last saw the deceased alive on 12-10, 1956, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert Wifrr M.D. ADDRESS (Street, city or town, state) Chestertown, Md DATE SIGNED 12-10-56

PHYSICIAN'S NAME (Type) ROBERT W. FHRR

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Dec. 13 1956

22c. NAME OF CEMETERY OR CREMATORY Chesterville Cem.

22d. LOCATION (City, town, or county) Chesterville (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Edward Pellowe ADDRESS Millington Md.

24a. REC'D BY REGISTRAR DATE DEC 17 1956

24b. REGISTRAR'S SIGNATURE Clara L Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12590

CERTIFICATE OF DEATH

12573

Reg. Dist. No. 2102

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE [illegible] b. COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, [illegible]
d. STREET ADDRESS [illegible] Harmon
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last [illegible]
4. DATE OF DEATH: Month [illegible] Day 7 Year 195[illegible]

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: [illegible]
9. AGE (In years last birthday) [illegible] yrs
IF UNDER 1 YEAR: Months [illegible] Days [illegible]
IF UNDER 24 HRS.: Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]
10b. KIND OF BUSINESS OR INDUSTRY [illegible]
11. BIRTHPLACE (State or foreign country) [illegible]
12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME [illegible]
14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [illegible] (If yes, give war or dates of service) [illegible]
16. SOCIAL SECURITY NO [illegible]
17. INFORMANT Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH [illegible]

DUE TO

I20.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary artery disease — [illegible]

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-7-[illegible], 195[illegible], to 12-7-5[illegible], 19[illegible], that I last saw the deceased alive on 12-7-[illegible], 19[illegible], and that death occurred at 12:5[illegible] PM, from the causes and on the date stated above.

ACTUAL SIGNATURE A.C. Dick M.D. ADDRESS (Street, city or town, state) Chestertown, [illegible] DATE SIGNED 12-7-5[illegible]

PHYSICIAN'S NAME (Type) A. C. Dick, [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec. 10, [illegible]
22c. NAME OF CEMETERY OR CREMATORY [illegible]
22d. LOCATION (City, town, or county) (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS [illegible]
24a. REC'D BY REGISTRAR DATE Dec. 8-56
24b. REGISTRAR'S SIGNATURE Clara L. Barnes

J. Willis Wells

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12574

12591 **CERTIFICATE OF DEATH**

Reg. Dist. No 202

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) [illegible]n
c. LENGTH OF STAY IN 1b [illegible]
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE [illegible]
b. COUNTY [illegible]t
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton Postoffice
d STREET ADDRESS [illegible]
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First [illegible] Middle W. Last [illegible]
4. DATE OF DEATH Month [illegible] Day [illegible] Year 19

5. SEX -
6. COLOR OR RACE [illegible]
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH [illegible]
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months [illegible] Days [illegible]
IF UNDER 24 HRS. Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Laborer
11 BIRTHPLACE (State or foreign country) [illegible]ent Co. Maryland
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Alec Comegys
14. MOTHER'S MAIDEN NAME Laura Jane Freeman

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [illegible]
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO [illegible]
17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse — INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
4-4-2 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cardiovascular renal disease — ???
DUE TO (c) Arteriosclerosis — ????

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Thermal burns of hands and arms, in September, 1956, from which he had recovered. General debility.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Burned at home, probably while lighting a fire.

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year Sept. 19 56
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) (State) Rural-Worton, Kent-Maryland.

21. I certify that I attended the deceased from 9-13, 19 56 to 12-9-, 19 56, that I last saw the deceased alive on 12-9, 19 56, and that death occurred at 12:15p M, from the causes and on the date stated above.

ACTUAL SIGNATURE A. C. Dick M.D.
ADDRESS (Street, city or town, state) Chestertown, Maryland
DATE SIGNED 12-10-56

PHYSICIAN'S NAME (Type) A. C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Dec. 15, 19[illegible]
22c. NAME OF CEMETERY OR CREMATORY [illegible]
22d. LOCATION (City, town, or county) (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells
ADDRESS [illegible]
24a. REC'D BY REGISTRAR Dec. 11-56
24b. REGISTRAR'S SIGNATURE Clarad Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12592

12575

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent and Queen Ann's

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 303 Kent Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle B. Last Ford

4. DATE OF DEATH: Month December Day 18 Year 19 56

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 8, 1896

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal clerk

10b. KIND OF BUSINESS OR INDUSTRY: P.O. Dept.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stephen Ford

14. MOTHER'S MAIDEN NAME: Essie Potts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Hospital records, Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary oedema — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Congestive heart failure — 3 days
DUE TO (c): Arteriosclerosis Auricullar fibrillation — 3 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-1, 19 56 to 12-18, 19 56 that I last saw the deceased alive on 12-18, 19 56, and that death occurred at 10:15a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D.
ADDRESS (Street, city or town, state): Chestertown, Md.
DATE SIGNED: 12-18-56

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 21/56
22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
22d. LOCATION (City, town, or county) (State): Chestertown, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Marvin V. Williams, Chestertown, Md.

24a. REC'D BY REGISTRAR: Dec 21-56

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12593

CERTIFICATE OF DEATH

12576

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: adult life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Chestertown

d. NAME OF HOSP. TAL (If not in hospital, give street address) OR INSTITUTION: R.F.D.

d. STREET ADDRESS: R.F.D.

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: J. Middle: Vincent Last: Grinnell

4. DATE OF DEATH: Month: Dec. Day: 5, Year: 19[illegible]6

5. SEX: [illegible]

6. COLOR OR RACE: [illegible]

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: [illegible], 188[illegible]

9. AGE (In years last birthday): [illegible] yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer

10b. KIND OF BUSINESS OR INDUSTRY: [illegible]

11. BIRTHPLACE (State or foreign country): [illegible]t. Mary's Co. Md.

12. CITIZEN OF WHAT COUNTRY? [illegible]

13. FATHER'S NAME: Sanford Grinnell

14. MOTHER'S MAIDEN NAME: Mary (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-36-[illegible]

17. INFORMANT: Minnie Grinnell Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO
(b): Hypertension
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-30, 19[illegible]6, to 12/9, 19[illegible]6, that I last saw the deceased alive on 12/4, 19[illegible]6, and that death occurred at 9 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Lester M.D. ADDRESS (Street, city or town, state): [illegible] DATE SIGNED: [illegible]

PHYSICIAN'S NAME (Type): [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: [illegible]

22c. NAME OF CEMETERY OR CREMATORY: Georgetown (col) Cem.

22d. LOCATION (City, town, or county) (State): Chestertc[illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: [illegible]

24a. REC'D BY REGISTRAR: DEC 11-56

24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12594

12577

CERTIFICATE OF DEATH

Reg. Dist. No. Jr 02

1. PLACE OF DEATH
a. COUNTY Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE — b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

c. LENGTH OF STAY IN 1b: Life

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hospital

d. STREET ADDRESS: 600 High St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Clarence — Middle: E. — Last: Hurd

4. DATE OF DEATH: Month: Dec. — Day: 15, — Year: 1956

5. SEX

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 3, 1880

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: Mechanic

11. BIRTHPLACE (State or foreign country): Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles E. Hurd

14. MOTHER'S MAIDEN NAME: Florence Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-18-7[illegible]

17. INFORMANT — Address: Mrs. Maggie Hurd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 7 mos.

DUE TO (b): Squamous cell carcinoma of tongue — 12 mos.

141 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-3-56, 19__, to 12-15, 19 56, that I last saw the deceased alive on 12-15, 19 56, and that death occurred at 5:15 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick — M.D. — ADDRESS (Street, city or town, state): Chestertown, Maryland — DATE SIGNED: 12-17-56

PHYSICIAN'S NAME (Type): A.C. Dick — Chestertown, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): B — 22b. DATE THEREOF: 12/20/56 — 22c. NAME OF CEMETERY OR CREMATORY: [illegible] — 22d. LOCATION (City, town, or county) (State): [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: [illegible]

24a. REC'D BY REGISTRAR — DATE: Dec. 18 1956 — 24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12595 CERTIFICATE OF DEATH

Reg. Dist. No. 12578 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 weeks
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kent & Queen Anne Hospital
d. STREET ADDRESS: RFD Tolchester
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Catherine Middle Mary Last Martenet
4. DATE OF DEATH: Month Dec. Day 18, Year 19 I956

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. I4, I899
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jefferson Davis
14. MOTHER'S MAIDEN NAME: Susie Hoskins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Martenet St. Clair Address: R.F.D. Tolchester Rock Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2½ weeks
DUE TO (b): Hypertensive cardio-vascular disease — years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443 ×

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1952 to Dec. 18, 1956, that I last saw the deceased alive on Dec. 17, 1956, and that death occurred at 8 30 A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Willard Smith M.D. ADDRESS (Street, city or town, state): Rock Hall, Md. DATE SIGNED: Dec. I9, I956
PHYSICIAN'S NAME (Type): Willard F. Smith - Rock Hall, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 2I, I956
22c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
22d. LOCATION (City, town, or county) (State): Baltimore, City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR DATE: Dec. 21-56
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12579

12597

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown R.F.D.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Fairlee

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairlee - Chestertown, Md.
d. STREET ADDRESS: R.F.D. Chestertown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First James — Middle Edward — Last Rowsey

4. DATE OF DEATH: Month Dec. xx — Day 9th — Year 1956

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1884
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lafayette Rowsey
14. MOTHER'S MAIDEN NAME: Margaret Hosetter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: yes
17. INFORMANT: Nora N. Rowsey — Address: Fairlee Chestertown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

442X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardiovascular renal disease; hypertension — ???

DUE TO (c): Arteriosclerosis — ????

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 5 1956 to Dec. 9 1956, that I last saw the deceased alive on Dec. 8 1956, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Dick M.D.
ADDRESS (Street, city or town, state): Chestertown, Maryland
DATE SIGNED: 12-10-56

PHYSICIAN'S NAME (Type): A.C. Dick

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 11, 1956
22c. NAME OF CEMETERY OR CREMATORY: Double Creek Cem.
22d. LOCATION (City, town, or county) (State): Queen Anne Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells
ADDRESS: Chestertown, Md.
24a. REC'D BY REGISTRAR: Dec. 11-1956
24b. REGISTRAR'S SIGNATURE: Clara L. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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